County of Los Angeles
CHIEF ADMINISTRATIVE OFFICE
713 KENNETH HAHN HALL OF ADMINISTRATION • LOS ANGELES, CALIFORNIA 90012
(213) 974-1101
http://cao.lacounty.gov

DAVID E. JANSSEN
Chief Administrative Officer

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To: Supervisor Zev Yaroslavsky, Chairman
Supervisor Gloria Molina
Supervisor Yvonne B. Burke
Supervisor Don Knabe
Supervisor Michael D. Antonovich

From: David E. Janssen
Chief Administrative Officer

Bruce A. Chernof, M.D.
Director and Chief Medical Officer
Department of Health Services

CALIFORNIA HEALTH CARE PROPOSALS AND UPDATE ON PROPOSED FEDERAL MEDICAID RULE (ITEM NO. 24, AGENDA OF JANUARY 23, 2007)

This is in response to the first part of the January 9, 2007 Board of Supervisors order directing the Chief Administrative Office (CAO) and the Department of Health Services (DHS) to analyze the fiscal and programmatic impact of Governor Schwarzenegger's Health Care Proposal and those proposed by Senate President pro Tem Perata and Assembly Speaker Nuñez and provide a report with specific recommendations. Also, a brief update of the proposed Medicaid rule, released on January 18, 2007, is provided.

HEALTH CARE REFORM PROPOSALS

Since the Governor's introduction of his Health Care Proposal of January 8, 2007, contained in Attachment A, there have been a flurry of meetings, discussions, and analyses by a broad array of potentially impacted stakeholders throughout California, all seeking to understand and assess the proposal's impact. These exchanges have produced a variety of documents, including several side-by-side comparisons of the

Governor's proposal with those introduced previously by Senate President pro Tem Perata and Assembly Speaker Nuñez. We have reviewed each of these comparisons and the three proposals to produce a synthesized comparison, primarily based on the California Hospital Association (CHA) document, which is included as Attachment B.

Governor's Health Care Reform Proposal

In all of the meetings and discussions in which we have been involved since January 8, 2007, the Governor's proposal has been the primary or exclusive focus. Briefly, the proposal would require:

- All California residents to have a minimum level of health care coverage ($5,000 deductible, maximum out-of-pocket $7,500 per person, $10,000 per family). Subsidies would be provided to residents unable to secure the minimum coverage level from their employers or their own resources. It is expected that this will extend coverage to the 4.8 million medically uninsured in the State.

- Increased reimbursement for hospitals and doctors by $10 billion to $15 billion ($4 billion from Medicaid) per year (from 45 cents on the dollar to 80 percent of what Medicare pays) and relieve them from the costs of caring for the uninsured.

- Counties to be responsible for covering 750,000 undocumented aliens.

- Extension of Medi-Cal eligibility to poor adults and Healthy Families/Medi-Cal to all children in families earning less than $60,000.

- A four percent of payroll contribution by employers of 10 persons or more which do not provide health coverage. Employers of less than 10 persons, which amount to 80 percent of all California employers, would be exempt.

- Eighty-five percent of all premiums received by health plans and insurers to be spent on patient care.

- Guaranteed coverage access, and provision of Healthy Action benefits by health plans and insurers. Healthy Action would be an incentive program to reward Californians for participation in evidence-based practices and behaviors that have been shown to both reduce the burden of disease and are cost effective.

- A new Statewide pool managed by the State Managed Risk Medical Insurance Board from which the medically uninsured will have expanded access to purchase coverage.

- Four percent and two percent fees on all hospital and doctor gross revenues, respectively.
- A national model for the prevention and treatment of diabetes.
- Electronic prescribing of all pharmaceuticals by 2010.
- New health and safety reporting requirements in California health facilities to reduce hospital acquired infections and medical errors by 10 percent over four years.
- Anti-obesity and tobacco campaigns.
- Redirection of health care safety net, realignment and other funding sources.
- Alignment of state tax laws with federal tax laws to allow pre-tax employee contributions to medical savings accounts.
- Employers to establish Section 125 plans to allow employees to make pre-tax contributions to health insurance.
- Adoption of a "worst first" approach to addressing hospital seismic safety requirements.
- Advanced adoption of health information technology.
- Linkage of future Medi-Cal provider and plan rate increases to specific performance measures.
- A new or revised Federal Medicaid 1115 waiver.

The total cost of the Governor's proposal is estimated to be $12.1 billion, funded in part by $2 billion from counties and $5.5 billion from the Federal government, as indicated in Attachment B. However, it appears that $1 billion from counties and $1 billion from the Federal government are existing expenses under the current Disproportionate Share Hospitals (DSH) Program. The remaining $1 billion from counties is indicated to be sourced from "Relief of County Obligations" which is, as yet, ambiguous. According to the California State Association of Counties (CSAC), the Administration advises that the Governor's proposal does not change the counties' Welfare and Institutions Code Section 17000 obligations, which require counties to provide health care services for indigent persons who are legal residents. The proposal diverts the entire Safety Net Care Pool of $766 million per year, under the current State 1115 Waiver, to subsidize

coverage for persons at 100 to 250 percent of the Federal poverty level ($542 million) and Medi-Cal rate increases ($224 million). For the current fiscal year, DHS alone anticipates receiving $208 million from the Safety Net Care Pool. We have also just submitted a "Coverage Initiative" proposal to the State which, if granted, would provide another $54 million to the County for health care from the Safety Net Care Pool.

As indicated in the abbreviated and partial listing of components above of the Governor's proposal, it is most extensive and far-reaching.

According to the CHA:

- The legislative process at times will be slow and laborious, and significant changes are expected as the Governor and Legislature debate these important policy questions with various stakeholders.

- While Governor Schwarzenegger and his Administration have provided the main elements of his health care proposal, it is not yet part of a piece of legislation. Thus, there are limited details on many elements of the proposal. It is possible that the Governor may not sponsor a specific bill containing his proposals, but instead work with the Legislature to insert elements of this proposal in other bills.

- Similarly, the proposals by Senate President pro Tem Perata and Speaker Nuñez are still spot bills at this point.

- Senator Sheila Kuehl is expected to reintroduce a version of her single payor bill that was vetoed by Governor Schwarzenegger last year. Republicans are also expected to introduce bills promoting health savings accounts, various tax incentives to provide health insurance, and mechanisms to reduce regulatory burdens and mandates.

We do not know at this point the extent to which the Governor discussed his proposal with the Federal government prior to its release. On its face, its seems to be at odds with the current 1115 waiver which prohibits provider taxes (as the Administration does not characterize the proposed fees on hospitals and doctors as taxes, but many feel they will be designated by Centers for Medicare and Medicaid Services (CMS) as such) during its term, and the proposal to increase Federal funding by $4.5 billion per year may be difficult given the size of the Federal budget deficit.

Potential legal issues include:

- Will the State need a constitutional amendment to divert Realignment revenues collected from vehicle license fees?

- Will a diversion of sales taxes from counties trigger Proposition 98 and redirect 40 percent of such diverted taxes to education?

- Does the Administration have authority under Proposition 1A to require counties to provide health care for undocumented aliens without providing additional funding to cover the cost of such care?

- Will the proposal to require employers to either provide coverage to workers or pay four percent of their payrolls into a state insurance pool be invalidated by Federal courts, as a similar proposal recently was in Maryland on the basis that it violates a Federal law governing employers' group health plans? Also, if this four percent levy is found to be a tax, it will require two-thirds vote of the Legislature.

Also, the Governor's proposal will take $1 billion in Health Realignment funding from counties. According to CSAC, a portion of vehicle license fees and sales tax revenue could be taken from the Realignment Health Account. For FY 2005-06 Statewide, the Realignment sales tax yielded $383 million for health services while vehicle license fees contributed approximately $1.1 billion. The County received $118 million and $364 million, respectively, from these accounts. Health Realignment revenues pay for indigent care and public health services.

Since the Governor's plan proposes to cover all indigent persons who are residing in California legally, the Administration believes counties would not need the full amount of Health Realignment revenues. The plan calls for these funds to be deposited into a health care fund at the State level, leaving $1 billion for counties to serve undocumented patients, those not yet enrolled in health plans, visitors, and persons with visas.

While the removal of the $1 billion from the Health Account may not directly impact the Realignment Mental Health and Social Services Accounts, the entire Realignment Program would likely need to be revisited, which would become a massive undertaking, and could lead to opposition by numerous stakeholder groups.

Senate President pro Tem Perata's Proposal

Senate President pro Tem Don Perata held a press conference on December 12, 2006 to unveil elements of his health care coverage proposal (introduced on January 3, 2007

as SB 48) which would provide insurance for 4.2 million of the 6.6 million Californians who are uninsured. The remaining 2.4 million people will continue to receive care through the county safety net. Senator Perata indicated that resolution of this issue is likely the key item facing the Legislature in 2007, and that this will be a starting point that will permit all interested parties to craft a plan to reduce the number of uninsured and the constant overcrowding facing hospital emergency rooms. Key elements of the proposal are as follows:

- All working Californians and their children would be eligible.

- The Managed Risk Medical Insurance Board (MRMIB) would be the broker, called the Connector, that would establish standards of coverage and use its purchasing power to negotiate favorable rates.

- The proposal would be paid for by employer and employee contributions similar to the California Unemployment and Disability Insurance programs and increased Federal funding would be pursued through the Healthy Families and Medi-Cal programs. Employer contributions and employee fees would be collected by the Employment Development Department and deposited into a new Health Insurance Trust Fund which would be used to buy health coverage for all eligible Californians.

- Employers would have the option to continue to provide health insurance or pay into a purchasing pool which would offer a variety of health plans from which employees could choose. Employees also would share the cost of health insurance premiums.

- The proposal would use new Federal funds, which ultimately may not become available, to subsidize the cost for low-income families, and to expand the current Healthy Families and Medi-Cal Programs to cover all eligible families and children up to 300 percent of the Federal poverty level. The State match for these Federal funds would come from the employer and employee contributions, and not from the State's General Fund.

Assembly Speaker Nuñez's Proposal

On December 21, 2006, Assembly Speaker Fabian Nuñez outlined his proposal to insure all children in the State and working Californians, and to ask employers to pay a fair share of coverage (introduced on December 4, 2006 as AB 8). A summary of the key features of the proposal follows:

- The Speaker's Fair Share Health Care proposal would provide coverage to all California children in households with incomes up to 300 percent of the Federal poverty level. In firms of two or more employees, both part-time and seasonal workers and their dependants would be covered. The self-employed would have enhanced access to coverage either through a State-level purchasing cooperative or a reformed private insurance market. The proposal would provide for primary coverage of Medi-Cal/Healthy Families program eligible employees and their dependants through an employer plan, if available, and would provide supplemental coverage to ensure Medi-Cal/Healthy Families benefit levels.

- The proposal would require employers to contribute to the cost of health care for workers and dependants in a "pay or play" model. Employers can pay for health care coverage, or pay a fee, based on a fair share percentage of payroll. For those opting to pay a fee, coverage would be available through a State cooperative purchasing program.

- All employees who are offered coverage at work would be required to accept coverage for themselves and their dependants. Employees whose employers choose to pay rather than offer coverage would pay a defined percentage of their income for coverage through the State cooperative purchasing program.

- The proposal would establish the California Cooperative Health Insurance Purchasing Program (Cal-CHIPP), administered by the Managed Risk Medical Insurance Board, to negotiate and purchase health insurance for employees whose employer chooses the pay option. Cal-CHIPP will offer at least three uniform benefit designs that will also be offered by all insurers in the private market. In addition, California will maximize federal funds by expanding coverage for low-income families through the Medi-Cal/Healthy Families programs.

The Speaker indicated that his health insurance plan will also include insurance reform, such as streamlining the medical underwriting process, and a variety of cost containment proposals including reducing uncompensated care, provision of preventive service and a disease management program.

Conclusion and Recommendations

Given that the health care reform proposals are Statewide, we have been, and will continue to, work with the California Association of Public Hospitals (CAPH), the DSH Task Force and CHA in assessing the impact of the proposals on the health care safety net Statewide and in our County and in proactively influencing the outcome to

advantage the health care safety net in our County. There is not enough specificity or data yet from the State to determine to what extent the proposed coverage of the medically uninsured and increased Medi-Cal and other insurance rates will offset the proposed redirection of "health care safety net, realignment" and Safety Net Care Pool funding.

Also, it is not known to what extent newly insured patients will continue to frequent County operated health facilities. CHA has retained a consultant to determine the impact of the Governor's proposal on each of its members (including this County). We will be evaluating the methodology used and its results as soon as the consultant's findings are made available to us. Similarly, we are actively working with CAPH on a model to determine the impact of the Governor's proposal and have begun a dialogue with State staff. A summary of this effort and many open questions are included in Attachment C. We will apprise you of results as they become available.

The County should continue to support the goal of extended health care coverage pursued by the proposals referenced above while, at the same time, using this opportunity to help stabilize the funding and critically needed services provided by the health care safety net in this State and County.

Further, the Board should direct the CAO and DHS, in conjunction with the State and health care associations cited above, to continue to pursue the development of financial models capable of accurately assessing the impact of various health care reform proposals and their revisions in the coming months. Based on the data produced by the models, the Board should direct the CAO and DHS to advise on appropriate actions to support or oppose various aspects of the proposals.

UPDATE OF THE PROPOSED FEDERAL MEDICAID RULE

On January 18, 2007, the CMS released a proposed rule that would, among other things, limit Medicaid reimbursement, excluding DSH, to the cost of treating Medicaid (Medi-Cal in California) patients. The rule has a 60 day comment period and is scheduled to be effective September 1, 2007.

We have reviewed the rule with legal counsel and program staff from both the National and California Associations of Public Hospitals, as well as our own contract legal counsel. Based on our review, we continue to believe the rule will likely jeopardize at least $200 million of annual Medi-Cal revenues we currently receive. An aggressive campaign against the rule has been, and continues to be, waged by both Associations, the American and California Hospital Associations, the National Governors Association and the majority of Congressional members. A DSH Task Force update of California's

Congressional delegation is being pursued for the end of this month, with the shared objective with other rule opponents of attempting to attach legislation addressing the rule to President "must-sign" legislation soon forthcoming, such as the continuing resolution scheduled for mid-February.

We also believe the rule could create serious problems for the health care reform proposals discussed above.

The Department of Health Services will prepare and submit comments to CMS in response to the proposed Medicaid rule, and the CAO and the Department will recommend future actions for the Board to take on behalf of the County in attempt to stop the rule or minimize its adverse impact.

Please let us know if you have any questions or desire further information.

DEJ:BAC:GWW

Attachments

c: Executive Officer, Board of Supervisors
County Counsel

GOVERNOR'S HEALTH CARE PROPOSAL

The Governor's vision for health reform is an accessible, efficient, and affordable health care system that promotes a healthier California through prevention and wellness and universality of coverage. For the Governor's vision to be realized, health care reform must reflect a "systems" approach that incorporates three essential building blocks in an integrated manner. These building blocks are:

Prevention, health promotion, and wellness
Coverage for all Californians
Affordability and cost containment

A. PREVENTION, HEALTH PROMOTION, AND WELLNESS

Preventable disease and disability have a profound impact on the health of California residents and communities as well as on the continued growth in health care costs. An increased emphasis on disease prevention, health promotion and healthy lifestyles will improve health outcomes and help contain health care costs. To promote a healthier California and achieve long term cost containment, the Governor's action steps include:

Structuring benefits and providing incentives/rewards to promote prevention, wellness, and healthy lifestyles through the implementation of "Healthy Actions Incentives/Rewards" programs in both the public and private sectors: Implement "Healthy Action Incentives/Rewards" programs in both the public and private sectors to encourage the adoption of healthy behaviors. Californians who take personal responsibility to increase healthy practices and behaviors, thereby reducing their risk of chronic medical conditions and the incidence of infectious diseases, will benefit from participation in this groundbreaking program. The Healthy Action Rewards/Incentives program will reward Californians for participation in evidence-based practices and behaviors that have been shown to both reduce the burden of disease and are cost-effective. Individuals in public programs, such as Medi-Cal and Healthy Families, will earn rewards that may include gym memberships or weight management programs. Participants enrolled in commercial plans, including CalPERS, will earn rewards and incentives, including premium reductions, for engaging in healthy activities. The Governor's plan includes the creation of a new insurance subsidy pool administered by the Managed Risk Medical Insurance Board through which low-income adults will be provided with subsidized coverage. The pool's coverage will also include a Healthy Action Incentive/Rewards program. All health plans and insurers will be required to offer a health benefit package(s) that includes incentives/rewards programs, including premium reduction, in the event that an employer wishes to make them available to their employees. All of the Healthy Actions programs are linked to the completion of a Health Risk Assessment and follow-up doctor visit.

Establishing a national model for the prevention and treatment of diabetes: Over 2 million Californians currently have diabetes, and the number of Californians with diabetes is expected to

double by 2025. Over one quarter of people with diabetes do not know they have the disease. To better prevent, target, and manage this high-cost chronic condition, Medi-Cal and the California Diabetes Program, in collaboration with community organizations, will jointly develop a comprehensive statewide initiative to institute proven interventions for pre-diabetes and diabetes screening, primary prevention, and self-management to reduce the number of people with diabetes or improve the health of those with the disease while reducing costly care within California's health care system.

Preventing medical errors and health care acquired infections: Medical errors and health care acquired infections unnecessarily compromise the health status of patients, lower health care quality and significantly contribute to health care costs. Patient harm due to such lapses causes an estimated 23,000 hospital deaths and untold numbers of injuries each year in California and costs over $4 billion annually. To combat this problem and significantly improve patient safety throughout California, the Governor will: (1) Require electronic prescribing by all providers and facilities by 2010 to substantially reduce adverse drug events; (2) Require new health care safety measures and reporting requirements in California's health facilities to reduce medical errors and hospital acquired infections by 10% over 4 years; (3) Call upon the leadership of California's health facilities to implement evidence-based measures to prevent harm to patients and provide state technical assistance; and (4) Create a university-based academic "re-engineering" curriculum designed to improve patient safety and streamline costs within the health care delivery system.

Reversing obesity trends through nation-leading innovative and comprehensive strategies: Obesity threatens to surpass tobacco as the leading cause of preventable death among Californians and costs the state $28.5 billion in health care costs, lost productivity, and workers' compensation. California can lead the nation in tackling obesity with the same success demonstrated in the state's anti-tobacco campaign. Based on the Governor's 10-Step Vision for a Healthy California, the Governor's proposal includes a sustained media campaign to encourage healthy choices; community-based activities to increase access to healthy food in stores and physical activity in schools and neighborhoods; employee wellness programs; and school-based strategies that engage the broader community in obesity prevention activities.

Continuing the battle against tobacco use: Smoking is the leading preventable cause of death in California. California has led the nation in effective smoking control activities, achieving the second lowest rate of smoking among adults in the nation. Still, an estimated 3.8 million adults and 200,000 youth smoke. California can maintain its leadership role in tobacco control and further reduce smoking rates by increasing access to cessation services offered through the highly effective California Smokers' Helpline and maximizing utilization of cessation benefits.

B. COVER ALL CALIFORNIANS

According to the UCLA California Health Interview Survey, 6.5 million Californians were uninsured at some point during last year, representing 20% of children and non-elderly adults. 75% of the uninsured were in working families, with the majority having no health coverage through their employers.

Addressing the "hidden tax" benefits everyone: A recent report by the New America Foundation estimated that a "hidden tax" on California health premiums has driven prices 10%

higher to help cover the costs of caring for the state's large numbers of uninsured. The study indicated that this annual "hidden tax" is $1,186 per California family and $455 for individual health insurance policies. This tax is even higher when underpayments from government purchasers such as Medi-Cal are added in.

Source: Dobson, Allen et al. (2006). The Cost-Shift Payment 'Hydraulic': Foundation, History, And Implications. Health Affairs, 25, no. 1: 22-33.

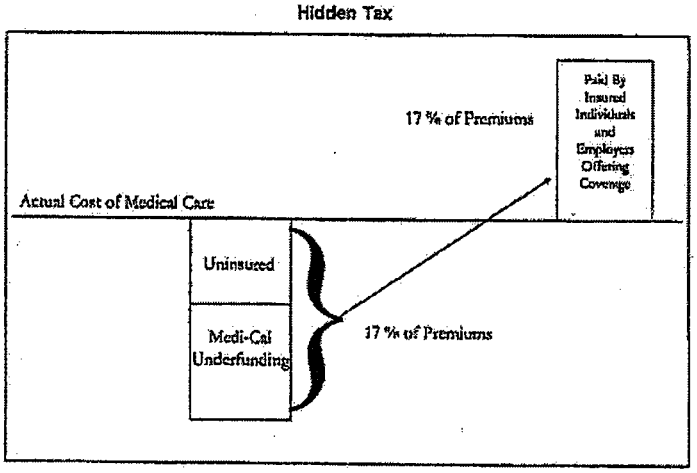

Figure 1: The effect of the "hidden tax" on insured individuals and employers offering coverage.

Ensuring availability of emergency rooms and trauma centers is essential: According to the Office of Statewide Health Planning and Development, 65 emergency rooms (ERs) in California have closed in the last decade. In Los Angeles County, one fifth of ERs have closed since 1995, leaving only 75 ERs open to the county's 10 million residents. A new study by the federal Centers for Disease Control and Prevention indicates that between 40% and 50% of emergency departments experienced overcrowding during 2003 and 2004. A major source of this overcrowding, especially in metropolitan areas, is the uninsured and persons who have problems accessing physicians through government programs such as Medi-Cal, which also contributes to emergency department and trauma center closures across California. As a result, the well-being and life of many Californians is threatened by longer drives to fewer ER facilities, longer waiting times, and compromised hospital capacity to cope with a major emergency, such as a disease outbreak or earthquake.

Availability of insurance affects not only the physical but the financial health of the community: A 2002 synthesis of 25 years of research on the uninsured conducted by the Kaiser Commission on Medicaid and the Uninsured found that the uninsured receive less preventive care, are diagnosed at more advanced stages of illness, have reduced annual earnings from work, and achieve reduced educational attainment. A National Institute of Medicine study indicated that the lack of insurance has resulted in a lost national economic productivity of $65 billion to $130 billion annually.

A February 2005 article in Health Affairs indicated that about half of the approximately 1.5 million American families that filed for bankruptcy in 2001 cited medical bills as the cause, which indicates that 1.9–2.2 million Americans (filers plus dependents) experienced bankruptcy due to lack of funds for medical expenses. The lack of insurance and underinsurance (less

comprehensive medical policies) were major contributors to the bankruptcies for the two years prior to 2005 as well. Numerous other articles have chronicled the sometimes catastrophic financial difficulties that individual families have encountered when facing uncovered health care costs.

To achieve coverage for all of California's uninsured, the Governor's action steps include:

Requiring all individuals to have a minimum level of coverage (individual mandate): Requiring people to carry coverage is the most effective strategy for fixing the broken health care system. The core problem for California is that those with insurance pay the cost of health care delivered to 6.5 million uninsured. Everyone must participate equally. An employer mandate will not achieve universal coverage because it fails to address the needs of part-time, seasonal, and unemployed uninsured Californians.

Providing low-income individuals affordable coverage: Low-income Californians will be provided expanded access to public programs, such as Medi-Cal and Healthy Families, and lower-income working residents will be provided financial assistance to help with the cost of coverage through a new state-administered purchasing pool.

Requiring insurers to issue health insurance: Insurers will be required to guarantee coverage, with limits on how much they can charge based on age or health status, so that all individuals have access to affordable products.

Increasing Medi-Cal rates significantly: To reduce the "hidden tax" associated with low Medi-Cal reimbursement and to encourage greater provider participation in the Medi-Cal program, Medi-Cal rates for providers, hospitals, and health plans will be increased.

Facilitating and enforcing the individual mandate: Systems will be established to facilitate enrollment of uninsured persons who use the health care system. Providers will play an important role in supporting enrollment by instituting such strategies as on-site enrollment at provider locations, as well as by underscoring the expectation that everyone present a coverage card at the point of service. In addition, the salary tax withholding and payment process with the Employment Development Department and the state income tax filing process will be utilized to promote compliance with the individual mandate.

Coverage Proposal Overview

6.5 million Californians are uninsured for all or part of a year; 4.8 million Californians are uninsured at any given time. The Governor's health care initiative identifies sufficient funds to cover all Californians through a variety of mechanisms. Jon Gruber, Ph.D., an MIT economist and health care expert, has assisted the Administration in estimating individual and employee behavior in the coverage model outlined below based upon coverage for all 4.8 million uninsured residents.

Coverage for uninsured children (approximately 750,000):

- All uninsured children below 300% of the federal poverty level (FPL), regardless of residency status, will be eligible for state-subsidized coverage. 220,000 uninsured

children below 100% of the FPL will enroll in Medi-Cal, while 250,000 uninsured children between 101-300% of the FPL will enroll in the Healthy Families Program. .

- 210,000 uninsured children will enroll in employer-sponsored coverage and an additional 50,000 uninsured children above 300% of the FPL will be covered by private insurance by their parents or responsible adult. Parents of these children will be responsible for purchasing at least the minimum level of coverage for their children.

Coverage for uninsured adults (approximately 4.1 Million):

- 630,000 uninsured legal resident adults with incomes below 100% of the FPL will be eligible for and enroll in no-cost Medi-Cal. This population has little discretionary income and purchasing Medi-Cal is a cost-effective coverage option.
- Approximately 1.2 million uninsured legal resident adults with incomes between 100-250% of the FPL will be eligible for coverage through a state purchasing pool operated by the Managed Risk Medical Insurance Board. Approximately 1 million are expected to enroll with the remaining 200,000 opting for employer-sponsored coverage.
- Consistent with the principle of shared responsibility, the individual/family contribution toward the premium will be as follows:

  100-150%: 3% of gross income
  151-200%: 4% of gross income
  201-250%: 6% of gross income

- Approximately 1.1 million uninsured legal resident adults above 250% of the FPL will not receive a subsidy and will be required to purchase and maintain coverage under the individual mandate. Of this amount, 370,000 are expected to opt for employer-sponsored coverage and 730,000 are expected to purchase individual coverage.
- There are approximately 1 million uninsured persons without a "green card" (primarily undocumented persons and persons with temporary visas). Of this amount, approximately 40,000 are expected to opt for employer-sponsored coverage and 160,000 are expected to purchase individual coverage. The remaining 750,000 under 250% of the FPL are expected to receive health coverage provided, coordinated or arranged by county government in coordination, where applicable, with county and University of California hospitals. Counties would retain $1 billion in current funding (primarily for outpatient services) and county and UC hospitals will retain $1 billion in federal Disproportionate Share Hospital (DSH) funds and in addition, some "safety net" funds for primarily inpatient services. The state will also continue to fund emergency Medi-Cal which provides certain vital services such as prenatal care and maternity for this population.

Payment assistance will be available for low-income insured adults: In order to maintain equity for low-income persons who are already contributing towards the cost of their care, persons with individual or employer-sponsored coverage who are between 100-250% of the poverty level will be eligible for state financial assistance through the purchasing pool. Approximately 700,000 persons are expected to utilize this option. Persons with employer sponsored coverage are eligible for state financial assistance through the purchasing pool for the employee share of the premium only if the employer contributes to the cost of coverage for those employees.

Anti crowd-out provisions are included to provide a disincentive to employers and employees from dropping current coverage. These include the 4% employer "in-lieu" fee for non-offering employers with 10 or more employees, purchasing pool premium contribution levels which are slightly higher than employee-only premium contribution levels, and a proposed provision that

will be added to the Labor Code making it an unfair business practice for an employer to differentiate the employer premium contribution by class of employee, except pursuant to a collective bargaining agreement.

In order to establish a more organized system of state-subsidized coverage that simplifies the eligibility system and maintains family unity of coverage, a "bright line" will be established between the Medi-Cal program and other subsidized programs (except for pregnant women). This would affect 680,000 children and 215,000 adult Medi-Cal enrollees above 100% of the FPL who would switch coverage to either the Healthy Families Program or the purchasing pool.

Source: Governor Schwarzenegger's health care team.

California's Family Health Insurance Programs

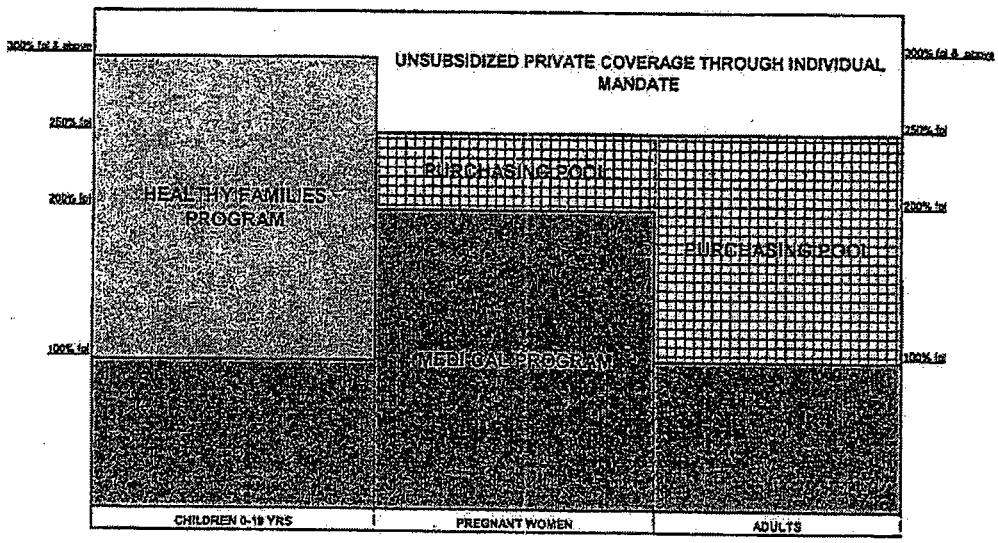

Figure 2: Proposed state coverage programs.

Everyone must maintain a minimum level of insurance:

- All Californians will be required to have health insurance coverage. Coverage must be substantial enough to protect families against catastrophic costs as well as minimize the "cost shift" that occurs when large numbers of persons are receiving care without paying the full cost of that care.
- The *minimum* health insurance benefit that must be maintained will be a $5,000 deductible plan with maximum out-of-pocket limits of $7,500 per person and $10,000 per family. For the majority of uninsured individuals, such coverage can be purchased today for $100 or less per month for an individual and $200 or less for two persons. Uninsured persons at any income level can purchase their own health coverage that meets the above requirement or, if income eligible, may obtain coverage with a state subsidy.
- Coverage through the new purchasing pool will fulfill an individual's obligation to obtain health coverage. The subsidized coverage through the purchasing pool is expected to be at the level of Knox-Keene medical benefits plus prescription drugs. Deductibles and/or co-payments that encourage the use of preventive benefits and discourage unnecessary use of emergency rooms will also be a part of the benefit package. The design of the subsidized benefit package will be the responsibility of MRMIB. Although dental and

vision benefits will not be included in the subsidized benefits, the pool will also offer non-subsidized products so that members can purchase richer benefits at their own expense. Persons between 100-250% FPL will have the option to purchase this subsidized coverage through the pool.

- Medi-Cal and Healthy Families Program benefits are expected to remain the same.
- Persons not eligible for a subsidy can purchase coverage that meets the minimum requirements in the private individual market. They can also access the mandated minimum $5,000 deductible product in the purchasing pool. Individuals will also be able to take advantage of the federal pre-tax premium deductions in either place if eligible.

Under shared responsibility, financing for expanded public programs, the subsidized health plan, increased Medi-Cal rates, and programs to promote prevention, health and wellness will be achieved through the following structure:

- Employers with 10 or more employees who choose not to offer health coverage will contribute an amount equal to 4% of payroll toward the cost of employees' health coverage.
- The plan will direct $10-$15 billion to hospitals and doctors, who will then return a portion of this coverage dividend associated with universal coverage; hospitals will contribute 4% of gross revenues and physicians will contribute 2% of gross revenues.
- The redirection of $2 billion in medically indigent care funding, which includes health care safety net, realignment, and other funding sources.
- Additional federal reimbursements for Healthy Families Program expansion, Medi-Cal rate increases, Medi-Cal coverage of parents as well as single adults through a Medi-Cal Section 1115 Waiver.

The proceeds from these revenue sources will be deposited into a newly established Health Care Services Fund. These funds will be segregated from the state general fund and will be the source for payment for health care coverage under the initiative.

Under the proposal, counties, county and University of California hospitals, will retain $2 billion in current funding for the uninsured. The State will continue to fund emergency Medi-Cal, which provides certain vital services, including emergency care, prenatal care and maternity services for this population.

C. AFFORDABILITY AND COST CONTAINMENT

Cost and coverage must be addressed together: without short- and long-term cost containment measures, the current system of health care delivery is not sustainable for employers and employees. With health care costs rising faster than general inflation, even more employers and employees will discontinue coverage and reliance on state health care programs will increase if health care affordability is not addressed. Cost containment becomes even more important with an individual mandate so individuals can afford to purchase and maintain comprehensive benefits.

Reduction of the "Hidden Tax:"

- When more Californians have coverage, providers will not need to continue loading their insurance charges with extra funds to make up for the cost of caring for those without coverage.
- Increased Medi-Cal reimbursement will further reduce the need of providers to shift uncompensated Medi-Cal costs to other payers.
- Employers will finally see an end to the annual premium cost-spikes they are currently experiencing. Providing health coverage to their employees will be more affordable.

Enhanced tax breaks for individuals and employers for the purchase of insurance:

- Align state tax laws with federal laws by allowing persons to make pre-tax contributions to individual health care insurance Health Savings Accounts.
- Require employers to establish "Section 125" plans so that employees can make tax-sheltered contributions to health insurance and save employers additional FICA contributions.

Enhance insurer and hospital efficiency:

- Require health plans (HMOs), insurers and hospitals to spend 85% of every dollar in premium and health spending on patient care.
- Revise the amount an insurer must pay a hospital when insured persons need treatment outside of their network so insurers will not need "defensive contracting" to protect against high daily rates from out-of-network providers.

Reduce regulatory barriers to more efficient health care delivery:

- Implement a new federal classification system for hospital construction and establish a new structural performance category to adopt a "worst first" system of hospital conformity to California's seismic safety requirements.
- Implement a "24-Hour Coverage" program that combines and coordinates the health care component of workers' compensation with traditional group health coverage. The proposed five-year pilot program for Cal-PERS (state and local agency employees) will ensure that health care services are delivered by the same set of providers used in the Cal-PERS managed care/HMO program for work and non-work-related health care. The private sector will be allowed to opt into the pilot.
- Remove statutory and regulatory barriers to expansion of lower-cost models of health care delivery such as retail-based medical clinics by making scope of practice changes for "physician extenders" such as nurse practitioners and physician assistants.

Reduce cost for delivering HMO products to employers and individuals:

- Review health/plan benefit, provider, and procedural mandates in order to reduce the cost of health care.
- Allow electronic submission of documents between insurers and their enrollees.
- Eliminate unnecessary health plan reporting requirements, such as the report on late grievances, antifraud, and arbitration reports, which are confusing and result in incomplete and/or not useful information.
- Streamline health insurance product approval.
- Develop a technology assessment process that will promote evidence-based care.

Prevention, health promotion, and wellness represent critical long-term cost containment strategies, as described above. Other key components for achieving long-term affordability include:

Health Information Technology (HIT): Health Information Technology offers great promise as one means to achieve more affordable, safe, and accessible health care for Californians while inside and outside of the state . Governor Schwarzenegger proposes the following action steps to advance the adoption of HIT throughout California:

- Providing state leadership and coordination by appointing a Deputy Secretary of HIT to lead and coordinate the state's HIT-related efforts to achieve 100% electronic health data exchange in the next 10 years.
- Improving patient safety through universal e-prescribing by 2010.
- Accelerating HIT by leveraging state purchasing, including support for uniform interoperability standards and HIT adoption, such as e-prescribing.
- Supporting consumer empowerment through use of standardized Personal Health Records (PHR) in the shorter-term within the public and private sectors that: are accessible via the internet and smart cards, are portable between health plans, and provide consumers with access to the core set of data in their PHR for their use and the use of their providers.
- At the county level, a pilot of an Electronic Medical Record system will be implemented, utilizing requirements under the Mental Health Services Act, creating an integrated network of care for mental health clients.
- Facilitating the use of innovative financing mechanisms, guided by a State HIT Financing Advisory Committee, to ensure the development of public/private partnerships and to meet capital needs for important HIT-related projects.
- Expanding broadband capabilities to facilitate the use of tele-medicine and tele-health, particularly in underserved areas throughout the state and stimulating the adoption of e-health technologies throughout the state through engagement of early tele-health adopters, communities in which they serve, technology firms, and community stakeholders.

Leverage state purchasing power through Medi-Cal:

- Increase Medi-Cal physician, hospital outpatient and inpatient, and health plan rates to promote a stable and sizeable provider network and assure continued timely access to health care for Medi-Cal beneficiaries and the broader population.
- Link future Medi-Cal provider and plan rate increases to specific performance improvements measures, including measuring and reporting quality information, improvements in health care efficiency and safety, and health information technology adoption.
- Pursue a Federal Medicaid 1115 waiver to maximize federal financing and support innovations in the financing and delivery of services through Medi-Cal. Such innovations can include the use of incentives and rewards for healthy behaviors, new strategies for diabetes prevention and management, adoption of health information technology, and strategies to rebalance the state's current system of long term care services in support of home and community-based services.

Enhance health care quality and efficiency:

- Provide a one-stop resource for information on health plan performance through the Office of the Patient Advocate website (www.opa.ca.gov) to increase the transparency of quality of care and access to other information to help inform consumers.
- Expand and strengthen the ability of the Office of Statewide Health Planning and Development to collect, integrate, and distribute data on health outcomes, costs, utilization, and pricing for use by providers, purchasers, and consumers so that additional health care data is available to inform and drive decision-making.
- Partner with private and public sector purchasers to promote the measurement and reporting of provider performance and the aggregation of data for quality improvement, pay for performance, and consumer choice.

We have a social, economic, and moral imperative to fix California's broken health care system and improve health care for all. Health care reform is essential to a healthy, productive, and economically competitive California. The foundation of the Governor's plan to expand health coverage and contain costs is a shared responsibility. Just as society as a whole shares in the benefits of universal coverage and health care affordability, so too is there a shared responsibility to secure universal coverage and contain health care costs. Over the course of the next year, the Governor and his Administration will work collaboratively with the Legislature, employers, health care insurers, and providers, and all Californians to create a national model for health care.

Source: Governor Schwarzenegger's health care team.

State Fiscal Impact Summary
(Dollars in Millions)

COSTS	STATE	LOCAL	FEDERAL	TOTAL COSTS	INDIVIDUAL TAX REDUCTION	SAFETY NET CARE POOL[1]
Increased Medi-Cal/Healthy Families Program Coverage	$1,283		$1,357	$2,638		
Subsidy for Persons 100% - 250% of FPL	$1,135		$1,135	$2,270		$542
Persons w/o Green Cards Provided Coverage by Counties		$1,000	$1,000	$2,000		
Prevention and Wellness Measures	$150		$150	$300		
Section 125 Tax Treatment (State Income Tax Reduction)	$900			$900	$900	
Section 125 Tax Treatment (Federal Income Tax and FICA Reduction)					$7,500	
Medi-Cal Rate Increase	$2,208		$1,832	$4,039		$224
TOTAL COSTS	$5,675	$1,000	$5,474	$12,147	$8,400	$766

REVENUES	
Employer 4% of Social Security Wages Payroll In-Lieu Fee (employers with <10 employees excluded)	$1,000
Provider Coverage Dividend (4% Gross Revenues from Hospitals and 2% from Physicians)[2]	$3,472
County Funds Available from Relief of County Obligations	$1,000
Savings from the elimination of State Programs[2]	$203
TOTAL REVENUES	$5,675

NET SURPLUS/SHORTFALL	$0

[1] Safety Net Care pool funding is included in the federal fund cost column and is split out in this column to show how these funds are being used.
[2] The Access for Infants and Mothers program, Managed Risk Medical Insurance Program and Medi-Cal Share-of-Cost will no longer be needed.

Figure 3: Fiscal impact of Governor's proposal.

Attachment B

COMPARISON OF HEALTH CARE REFORM PROPOSALS

Key Features	Governor Schwarzenegger	Speaker Núñez (AB 8)	President Pro Tem Perata (SB 48)
1. Who is covered	All Californians. See #11 regarding Undocs	All Californians within 5 years, with first priority coverage for all children by 2008. Expands coverage to reach unemployed single adults within 5 years.	All working Californians and their dependents.
2. How people are covered	Employment-based coverage, a partially subsidized purchasing pool, individual coverage, expanded eligibility for Medi-Cal and Healthy Families.	Employment-based coverage, a partially subsidized purchasing pool, individual coverage, expanded eligibility for Medi-Cal and Healthy Families programs.	Employer-provided coverage, a partially subsidized purchasing pool, the "Health Insurance Connector," individual coverage, expanded eligibility for Medi-Cal and Healthy Families.
3. Minimum covered benefits	Knox-Keene-mandated benefits and prescription drugs, with maximum deductible of $5,000.	To be determined by MRMIB.	Several options (with varying out-of-pocket costs) to be determined by MRMIB.
4. Employers	Employers with 10 or more employees who choose not to offer health coverage for employees and their dependents will pay 4% of payroll to purchasing pool. Cost-shift reduced and costs contained. Employer-sponsored coverage: • 100-150% FPL - 3% of gross income • 151-200% FPL - 4% of gross income • 201-250% FPL - 6% of gross income • 250% FPL > no subsidy and required to purchase & maintain coverage.	Employers must offer coverage for employees and their dependents or pay a fee based upon a "fair share" percentage of payroll. Businesses with 2 or fewer employees and less than $100,000 in payroll would be exempt.	All employers would be required to spend a yet-to-be-determined percentage of social security of wages on health coverage or contribute an equal amount to a health insurance trust fund.
5. Individuals	Individual and employee mandates. Individuals must secure and maintain a minimum	No individual mandate, but employees would be required to accept coverage when offered by employer, provided it does not exceed a	All working Californians would be required to contribute to coverage. Employee fees would be withheld and paid to EDD.

Key Features	Governor Schwarzenegger	Speaker Núñez (AB 8)	President Pro Tem Perata (SB 48)
	level of health coverage. For low-income people, options include enrollment in public programs or subsidized private coverage through the purchasing pool. Tax break (pre-tax dollars) withholding with EDD to promote compliance. Requires Section 125 plan by employers.	"reasonable percentage" of their income. Self-employed would obtain access through a state pool or a reformed individual market. Tax break (pre-tax dollars) for employees. Requires Section 125 plan by employers.	Low-income people could use public programs or partially subsidized private coverage. Employees would be required to show proof of coverage for claiming certain taxes.
6. Health plans and insurers	Must guarantee access to coverage in individual market (guaranteed issue and age-adjusted rating). Must spend 85% of premiums on patient care. Must make "Healthy Actions" benefits available to promote healthy behaviors.	Guaranteed issue and community rating in individual markets.	Standardizes rating practices. Plans contracting with the Health Insurance Connector would be required to cap administrative expenses and implement evidence-based practices. Guaranteed issue to individuals through the Health Insurance Connector.
7. Hospitals	Increase in Medi-Cal inpatient payments to 100 percent of Medicare rates and Medi-Cal outpatient rates to 80 percent of Medicare outpatient rates, with some of the increase paid for by current safety-net funding. Substantial reduction in uncompensated and under-compensated care. Hospitals are required to pay 4% of revenues to help fund health coverage subsidies. See also "Cost containment and affordability" below.	Expansion of coverage should decrease uncompensated care and inappropriate emergency department use.	Expansion of coverage should decrease uncompensated care and inappropriate emergency department use.
8. Physicians	Significant increase in Medi-Cal payments. Physicians are required to pay 2% of patient	See "Cost containment and affordability" below.	See "Cost containment and affordability" below.

Key Features	Governor Schwarzenegger	Speaker Núñez (AB 8)	President Pro Tem Perata (SB 48)
	revenues to help fund health coverage.		
9. Cost containment and affordability	Promotes fitness and healthy lifestyles, places caps on plans' administrative costs, eliminates cost-shifting, places caps on hospitals' administrative costs, simplifies benefit plans to permit comparison shopping, reduces medical errors, develops health information technology, rewards good healthy behaviors, reconsiders state mandates, reduces regulatory barriers to efficient health care delivery.	Ensures coverage of preventative care and disease management, speeds progress toward universal adoption of electronic health records, and promotes health lifestyles, reduce cost-shifting.	Includes preventative care, case management for chronic diseases, caps on administrative costs of health plans, standardized billing practices, reduction of medical errors, patient cost-sharing, requirements to adopt evidence-based practices, promotion of healthy lifestyles and "rational use" of new technology, reduction in cost shifting.
10. Public programs (state/federal)	Medi-Cal rates to be "significantly increased." Medi-Cal and Healthy Families expanded to cover up to 300 percent of FPL. Medi-Cal expanded to cover poor adults. Needs Section 1115 waiver.	Healthy Families and Medi-Cal would be expanded to cover children and their parents up to 300 percent of FPL. Needs federal support and funding.	Subject to future appropriation of funds, Healthy Families and Medi-Cal would be expanded to cover children and their parents up to 300 percent of FPL and for adults up to 250 percent. New federal funds needed.
11. Health care safety net and "county indigents"	State becomes responsible for all Californians except undocumented adults. State takes most of the safety-net pool funds and half of county match, redirecting it to Medi-Cal. $2 billion is left with counties and safety-net providers.	County indigent programs become a state responsibility within 5 years contingent on a Medi-Cal waiver.	Not addressed.

Sources: SB 48 (Perata), as introduced. Descriptive materials issued by Speaker Núñez, President Pro Tem Perata, and by Governor Schwarzenegger.

Note: This side-by-side is for broad comparison purposes. The proposals are complex, detailed and comprehensive — this format cannot fully reflect all of their significant details and implications.

ATTACHMENT C

CALIFORNIA ASSOCIATION OF PUBLIC HOSPITALS AND HEALTH SYSTEMS

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Financing of Governor's Health Reform Proposal – Elements of Analysis

Relationship to Medi-Cal Financing Waiver

The Governor's proposal makes significant changes to the funding streams and processes established in SB1100 and the Special Terms & Conditions (STCs) of CA's 1115 waiver. State staff have indicated that the plan will require an 1115 Waiver in order to expand Medi-Cal to adults under 100% of FPL, and that it is likely that CMS would have that rolled up into a revised version of the current waiver. The following are the key changes to the Waiver funding that the Governor's plan proposes (for additional information, see attached chart):

1. Medi-Cal Inpatient Fee-For-Service Payments:
   a. 23 Designated Public Hospitals: State General Fund of $599 million for rate increases. This State General Fund will enable the hospitals to achieve more than the current 50% reimbursement of Medi-Cal costs. The method for allocating this State General Fund among the hospitals has not been disclosed.
   b. All Other Contracting Hospitals: Rates will be increased to 80% of Medicare, indicating no need for CMAC negotiated rates.

2. DSH Payments:
   a. 23 Designated Public Hospitals: The $1.024 billion will be available to be drawn down using a combination of IGT & CPE. This money is mainly intended to help cover the cost of services to undocumented immigrants and any other remaining uninsured. The method for allocating these dollars has not been disclosed.
   b. Private DSH Hospitals: The DSH-Replacement Fund will no longer exist. According to the State, they believe the increase in Medi-Cal rates to these hospitals will provide sufficient reimbursement so that the DSH-Replacement Fund is no longer needed.

3. Safety Net Care Pool: The Governor's Plan calls for using most of the SNCP ($542 million of the $766 million) to help fund the subsidized coverage for adults between 100% and 250% FPL. The remaining SNCP dollars ($242 million) will be available for the 23 designated public hospitals to draw down using CPE.

4. Private & Non-Designated Public Hospital Supplemental Funds: These funds will no longer exist for the same reason given in #2b.

5. Prohibition on Provider Taxes: The STCs specifically prohibit the State from imposing any provider taxes/fees that will be used as the non-federal share for Medicaid payments. The State has indicated that they plan to renegotiate this so that the new hospital and physician coverage dividend fees will be an acceptable source of non-federal share.

70 Washington Street ■ Suite 310 ■ Oakland, CA 94607 ■ 510.874.7100 ■ 510.874.7111 (fax)

New & Retained Funding, Diverted & Lost Funding, and Unknown Financing Impacts to Public Hospitals and Counties

The Governor's Proposal contains several elements that provide for funding increases to public hospitals as well as elements that result in loss of dollars. CAPH is working on a more complete analysis of these items and their combined impact. This analysis will require additional information from both the members and the State; those items are indicated in bold.

New & Retained Funding

1. Increased Medi-Cal Rates: $599 million in State General Fund. **We do not know how these funds will be allocated or how this amount will grow in future years.**
2. Increased Medi-Cal due to expanded eligibility: **How many of the newly Medi-Cal eligible (adults under 100% FPL) will be seen in the public hospitals?**
3. Retention of DSH funds: Public hospitals retain $1.024 in DSH funds. **We do not now how these funds will be allocated. Will there be sufficient remaining uninsured costs and available IGT to draw down the full amount of funds?**
4. Retention of a portion of the SNCP: Public hospitals retain $242 million. **Will there be sufficient remaining uninsured costs to draw down the full amount of funds? If most of the remaining uninsured are undocumented immigrants, will CMS still only require that they hospitals reduce costs eligible for the SNCP by the 17.79% reduction?**
5. Insurance payments for previously uninsured individuals. **What will rates from the new plans be? What services will be covered?**

Diverted & Lost Funding

1. Diversion of $1 billion in county realignment to fund subsidized coverage for adults. **How will the State determine which county realignment dollars are diverted and which remain? How many of these diverted dollars are currently funding the provision of health care in public hospitals? What else was funded through these dollars that will no longer have sufficient funding?**
2. Diversion of $542 million of SNCP to fund subsidized coverage for adults. **How will the State propose to drawn down these funds? Is the Coverage Initiative eliminated?**
3. Provider Coverage Dividend: Hospitals will be required to pay 4% of "gross revenues" to the state to help fund this proposal. **What is the definition of "gross revenues?"**

Unknown Impact

1. New requirement that hospitals must spend 85% of "health spending" on patient care. **What is the definition of "health spending?" What is the enforcement mechanism? Are there any public hospitals that do not think that they can meet this requirement?**
2. Possible impact on current commercial plan rates. **With this proposal focused on reducing the "hidden tax", will plans be able to successfully argue for reduced payments to providers?**
3. Uninsured costs at public hospitals should decrease due to new insurance coverage. **What portion of the current uninsured costs will be eliminated due to new insurance coverage?**
4. Remaining uninsured/other uncompensated costs. **How much uncompensated cost will remain due to high-deductibles and other out-of-pocket expenses that newly insured low-income individuals cannot pay? What are the uninsured costs associated with undocumented immigrants and other remaining uninsured individuals? How will these costs and the remaining unfunded Medi-Cal costs be financed?**